LISKEARD RURAL DISTRICT COUNCIL.

THE

ANNUAL REPORT

OF THE

MEDICAL OFFICER OF HEALTH

For the Year 1950.

P. J. FOX, M.B., B.Ch., B.O.A., D.P.H.

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To the Chairman and Members of the Liskeard Rural District Council.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report for the year 1950. As you are aware I hold a dual appointment, so that in addition to being Medical Officer of Health to six District Councils in South-east Cornwall I am also an Assistant County Medical Officer. In the latter capacity I represent the County Medical Officer, and am responsible for the day to day administration of certain sections of the National Health Service Act, 1946. Although District Councils have no statutory responsibility in the provision of health services under these sections of the Act, the fact that through the County precept on their rates they contribute to the cost of these services, will make them interested in the nature of the service provided. I shall therefore refer to some of these services, which in my view merit comment, and which I believe are not fully understood by members and officials of District Councils.

Dealing with health matters in all six County Districts in Health Area No. VII of the County I not un-naturally view these matters more frequently against the background of conditions in the Health Area as a whole rather than against that of the individual County District. Since social, economic, climatic and other conditions bearing on the health of the community do not vary substantially from one County District to another in Health Area No. VII, it is not surprising to find that conclusions drawn from the Area as a whole are valid for individual County Districts in that Area. For this reason, and because my work as an Assistant County Medical Officer is carried out on an Area basis, I propose to make the preface to each of my six Annual Reports a general preface, and to deal in the body of the Report with local variations from the state of affairs which obtains in the Health Area as a whole.

Health Area No. VII of Cornwall County embraces the Municipal Boroughs of Liskeard and Saltash, the Urban Districts of Looe and Torpoint, and the Rural Districts of Liskeard and St. Germans. Its total area is 164,000 acres and the total population is just over 50,000. Some 60% of the total population lives in the two Rural Districts, the remaining 40% being in the four small urban areas which make up the Health Area. There is no appreciable heavy industry in the Area, the emphasis being on agriculture. During the summer months there is a heavy influx of holiday makers to the coast which bounds the Area on the south, the chief centre of this activity being Looe. Though in theory such an influx may carry with it the risk of importing infectious disease into the Area, in practice this does not often happen. During 1950 there was some concern lest poliomyelitis, which was prevalent in many

parts of the country, particularly the midlands, might be brought to Cornwall by visitors. In fact three visitors from the Birmingham district developed the disease soon after arrival in Cornwall but in spite of the fact that the resort at which they were staying was extremely crowded, there was no extension of the disease to other visitors or the local population.

In referring to the state of health of the community in Area VII in general terms it is I think correct to say that on the whole it is up to the average of the country as a whole. Cornwall is a favourite place of retirement for those whose working days are over, and in consequence the population here contains a higher proportion of older people than the country as a whole. Knowing this, it is reasonable to expect that the death rate in Cornwall would be higher than the country as a whole, and this is what our statistics reveal. The fact that the average age at death is above that of the Country as a whole shows that the higher death rate is in this case no indictment of the state of health of the community. The birth rate is below the national average for similar reasons beyond our control. The absence of industry, with the attendant lack of employment for young people, means that numbers of people in the younger age groups leave Cornwall to work and live, and raise their families elsewhere.

Of the preventible diseases the most serious without a doubt is tuberculosis Apart from the loss of life which it causes, the chronic invalidism which accompanies it represents a serious economic loss to the Community. The period of inability to work and earn a living is measured in tuberculosis, not in days or weeks but more often in months and years. It most frequently affects persons in early adult life, thereby invaliding them at what is normally their most active and productive phase of life. Moreover because of its communicable nature its victims inevitably suffer some social ostracism, though the position here has improved somewhat, and tuberculosis no longer carries with it the social stigma it did some years ago. It would not be unreasonable to expect that heroic measures would be called for, and would be justified in dealing with such a disease. Admittedly such measures would be expensive to put into operation, at least at the outset, but properly applied they would soon have shown returns not only in reducing human suffering, but also lessening the size of the economic burden that tuberculosis places on the community. In fact tuberculosis has been, and is still regarded with too much complacency, and with an outlook that breathes too much of despair. The prompt removal of the tuberculosis patient, and his retention in a place of isolation—the sanatorium—is still in too many cases—a counsel of perfection, and so the patient remains at home, and often spreads the infection to another member of the household. We are all aware of the long waiting lists for admission to sanatoria, since from time to time articles and correspondence in the press give the matter some prominence. I do not wish to minimise the difficulties which beset those who wish and who endeavour to improve the facilities for the treatment of tuberculosis. The prime difficulty is that of providing sufficient nurses to adequately staff even the number of beds at present available, and the difficulty is correspondingly greater if regard is

given to the number of beds which would be required to fully satisfy the needs of tuberculosis. I do not believe that the inadequacy of sanatorium accommodation is any worse in Cornwall than in the country as a whole, but there is no doubt of its existence. Of the 53 cases of pulmonary tuberculosis notified during 1950 in Health Area VII only seven gained admission to Tehidy Sanatorium that year, i.e. one person in every seven suffering from tuberculosis can hope to be admitted to a sanatorium in the early stages of the disease. In spite of the difficulties associated with the provision and staffing of sanatoria, and chest clinics, I feel that a bigger proportion of the expenditure on the National Health Service should be devoted to the prevention and treatment of this chronic, crippling disease. I feel that if some of the money which has been spent on the over-lavish provision of other less-essential items in the National Health Service had been diverted to the prevention and treatment of really serious disease we should be on the right road to eradicating such scourges as tuberculosis from our midst. Viewed statistically there has been little or no change in the incidence of or mortality from tuberculosis in Health Area No. VII over the past three years, and the figures are on a par with those for the County as a whole. These statistics are given as an appendix to this report. Towards the end of 1950 a start was made on the B.C.G. vaccination scheme. This vaccine which has been extensively used on the Continent, especially in Scandinavia, has been found to stimulate in the body some resistance to tuberculous infection. At present, its use is confined to those persons who are exposed to a definite risk of contracting the disease e.g. close contacts of a case, nurses, and who have not developed any resistance to the disease. The necessity for removing suitable candidates for B.C.G. vaccination from any risk of infection for six weeks before vaccination, and six weeks after vaccination is a serious obstacle, and one which makes even more necessary the early removal to a sanatorium of cases, particularly where there are susceptible young adults and children in the household. I cannot leave the subject of tuberculosis without a reference to the importance of adequate housing in relation to this disease. One of the most important services a District Council can render to a family in which there is tuberculosis, is the provision of satisfactory housing, with adequate space, so that if at all possible the sufferer should have a separate bedroom. This measure of prevention is within the control of the District Council, when they are powerless to influence the provision of hospital accommodation, and I would therefore commend to all District Councils the claim of the tuberculosis patient on housing.

Another matter which has caused concern during the year is the inadequate provision for the care of chronic sickness occurring amongst aged and infirm persons. At the only hospital in this Area dealing with this type of case, there is invariably a long waiting list for admission. I do not wish to be critical of this state of affairs, but I feel bound to express my concern. Again much of the difficulty arises from shortage of staff—both nursing and domestic. It must be admitted that the care of aged, chronically ill people is not a very attractive career. It does not call so much for technical skill, as for a sense of devotion to the service of those unfortunate fellow-creatures, who

through the burden of years, and infirmity are unable to care for themselves. Endeavours have been made to meet the need, by providing a shorter and less technical course of training for Assistant Nurses who would form the bulk of the nursing staff in hospitals for aged and chronic sick. As far as I can gather the response from suitable young women and men has not so far been very encouraging and it would appear that this difficulty is one which will not easily be overcome. Again I feel that the care of chronic and aged sick might have received more and better consideration in the National Health Service, particularly as the proportion of older people in the community is on the increase, and there appears to be a tendency for relatives to leave their old folks to the Welfare State to be taken care of. There is some provision in the National Assistance Act whereby old and infirm persons who are adjudged by a court of summary jurisdiction as being incapable of caring for themselves can be removed to an institution or hospital on the order of the court. This piece of legislation, which is a direct interference with the liberty of the subject is one which I personally have not been called upon to certify as necessary in any case, though in at least two cases it has been given serious consideration. The fact that seven days notice of the making of this application must be given to the court and to the person managing the premises to which it is intended that the aged or infirm person should be removed, makes this the use of this section unsuitable for dealing with urgent cases.

One of the greatest triumphs of preventive medicine has been the virtual eradication of diphtheria from the community as a result of the successful immunisation campaign which has been in progress throughout the country over the past ten years. The success of this campaign can be measured by the reduction in the number of cases notified. Thus in 1940, in the County of Cornwall 392 cases of diphtheria were notified, while in 1949 the figure had fallen to three—a truly wonderful result. During the years 1948—1950 inclusive, in the whole of Health Area No. VII one case only of this disease has been notified to me. It would be a thousand pities if the valuable gains of the last decade in this sphere of public health were to be lost through apathy or groundless fears of the alleged ill-effects of immunisation on that other scourge of childhood—poliomyelitis. The absence of a disease from the community tends to breed in that community a sense of apathy towards the potential dangers and consequences of that disease. It is understandable that most young parents whose memories of the disease as it existed in their childhood have grown dim, and who know nothing of it in relation to their own or their neighbours children, should sometimes fail to realise the seriousness of the position which will arise if large numbers of the rising generation of children are not protected by immunisation. Unfortunately certain conjectures on the possible effect of recent diptheria immunisation on the incidence, and severity of paralytic poliomyelitis found their way into the popular press during 1950, and created in the minds of parents a certain amount of opposition to diptheria immunisation. There has been no clear proof that such adverse effect does in fact follow diphtheria immunisation, and in at least one recent report no such association could be found. Diphtheria has not wholly vanished from the country, and given suitable soil—a child population with an in-

creasing number of non-immunes—it will soon re-establish itself, and will again become one of the grim reapers of young lives.

Another disease which affects children and adolescents is poliomyelitis. This disease is perhaps better known as infantile paralysis, though in fact it can attack adults, and it does not always cause paralysis. The virus which causes it has become much more widespread in recent years in the British Isles, and outbreaks of this disease have appeared without fail each summer and autumn in sufficient numbers to attract attention since 1947. The mode of infection and subsequent spread of the disease is difficult to trace, and it is common to meet isolated cases where there is no obvious source of infection, and the disease does not spread any further. Infection is probably spread by droplets from the nose, mouth and throat and probably also from the bowel Because of its morbid " news value " the disease has received a good deal of publicity in national and local newspapers, and the general public, especially the parents of young children have become very " polio " conscious. Unfortunately this gives rise to a good deal of unreasonable anxiety, amounting in some cases to panic, and the occurrence of a case of poliomyelitis is almost always accompanied by rumour and speculation which bears little relation to the true state of affairs. There is great need to take a balanced and reasonable view of this disease, so that parents may be spared undue distress and worry. Although the disease is notorious for the paralysis it can and does cause, about 25%—30% of the cases notified in 1950 throughout the country did not suffer from paralysis. Again during 1947 when poliomyelitis was present in this country in epidemic form, there were 688 deaths from this disease, whereas tuberculosis caused 23,075 deaths and 4071 persons were killed in traffic accidents. Thus whilst poliomyelitis is a serious disease, it is important that we keep it in its proper perspective in relation to other hazards to life, and limb. As far as Health Area No. VII was concerned the incidence of poliomyelitis during 1950 was considerably above that for the two previous years. In all 14 cases were notified of which 10 were accompanied by paralysis, while in four there was no paralysis. There were no deaths from this disease. The case rate per 1000 of the population was 0.27 as against a rate of 0.18 for England and Wales as a whole.

Of the other infectious diseases notified during 1950 whooping cough and pneumonia were most numerous. With pneumonia, erysipelas and meningitis the local case rates were above the national figure, whilst with measles, whooping cough, scarlet fever and puerperal pyrexia the local case rates were better than those for England and Wales.

In my report for 1949 I referred to the supremely important part played by housing in the national economy. The demand for new houses continues unabated, and everywhere the claims of eager applicants outnumber the new dwellings which can be made available. The only factor which puts any curb on the apparently insatiable demand for new houses, is the relatively high rent which now attaches to new houses. This is the inevitable result of increased costs of wages and materials operating in the building industry. As far as housing is concerned it is interesting to observe that the fulfilment

of the manual workers demand for higher renumeration, and increased leisure has reflected back so adversely on themselves, and their families when they require to be rehoused. Many relatively well-paid manual workers are now finding it difficult to meet the high rents which are due in part to the higher wages paid to their colleagues, in the building industry. As far as social welfare, and public health are concerned it is most unfortunate that these factors should operate against the rehousing of those who require it, but it is not a matter which can be easily remedied. National and local financial resources are strained to well nigh breaking point, and the provision of further subsidies for housing, food or indeed any other public service is almost out of the question. Nothing short of increased productivity, and the best possible use of scarce and expensive materials holds out any hope for rehousing those who most require it at a cost they can afford to pay. It is hardly necessary to remind you that the provision of good housing is dependent on the availability of ancillary services, with water supply in the forefront. The progress of housing schemes is made much more difficult by the absence of these services, a fact which many of the less progressive rural areas throughout the country are now discovering in the very hard, and very expensive post-war school of experience. Considering all the difficulties which surround the problem of providing an adequate number of new houses together with the requisite ancillary services, I consider that District Councils in this Area have all made very good efforts in this direction.

Water supplies in the Area are variable, ranging from piped supplies of pure water to indifferent and dangerously polluted supplies from shallow wells and springs. In all cases there is anxiety during the dry summer months concerning the quantity of water available, and with piped supplies restrictions on consumption are usually necessary. In the case of the smaller schemes in villages and hamlets there is sometimes complete failure of the supply and expensive and inadequate substitutes have to be provided. The Liskeard Rural District Council and the Liskeard Borough Council have embarked upon a joint scheme of considerable magnitude, which has as its object the provision of a pure supply of piped water to the whole of the Liskeard and Rural District, at present badly served in this respect. As with all undertakings of this description the progress of the work is frustrated and impeded by shortage of materials, and the ever present bogey of rising costs. It is also worth remembering that the demands of the defence programme and such measures as the National Health Service or the national income are so heavy, and pressing that Governments grants to aid local schemes and projects of water supply, and sewerage may be much less generous than had been anticipated. This will lay a correspondingly heavier burden on local finances, and it may well be found that comprehensive schemes of water supply and sewerage though necessary, and long overdue cannot be undertaken through lack of ability to meet the high cost of such schemes.

The standard of sewerage and sewage disposal is generally unsatisfactory throughout this Area. In only one of the larger urban communities is any attempt made to treat sewage before discharging it to a waterway, and

even here the plant used is obsolescent and unsatisfactory. In villages and hamlets in the rural parts of the Area arrangements for sewerage and sewage disposal are generally primitive, inadequate and unsatisfactory. It is true that where new houses are constructed efforts are made to improve the state of affairs, and provided such small sewage disposal plants are carefully and regularly maintained they are tolerably efficient. As with water supply schemes the planning and provision of larger sewerage schemes is delayed and discouraged by a multitude of difficulties, the greatest of which is the high cost of such schemes. No one is prepared to argue against the necessity for the provision of water and sewage disposal—indeed the modern citizen and rate-payer regards these services less and less as amenities and more and more as the bare and basic necessities of life, especially if he has come from districts where they have been provided. Whilst as an official primarily concerned with the prevention of disease and the promotion of health I must advise and even urge the provision of these services, nevertheless I must temper my enthusiasm with a sense of reality. Unfortunately the harsh and easily perceptible reality of the matter is our physical and financial inability to provide these services. In thinly populated rural areas the over-riding difficulty is one of finance, though shortage of labour, and materials and transport difficulties all contribute to the slow progress in solving these problems. During and since the war many city and town dwellers have come to rural areas to live. They have in most cases been appalled by the primitive conditions existing in many rural areas and some have been vociferous in their demands for those things which are the normal concomitants of life in a large community. Whilst we must never abate our efforts to improve living conditions in rural areas, we must recognise the formidable financial and physical obstacles which confront our endeavours in this direction, and we must never lose sight of the magnitude of these problems.

It is not perhaps generally understood that the social services, of which the public health service is one, are in effect purchasable commodities, and have to be paid for out of a fixed and limited national income. However much a private individual may wish to spend on the promotion and preservation of his health, the size of his income inevitably places some limit to the amount he may devote to this purpose. This is equally true in the national life, and limits the size and scope of any service, to that which the community can pay for. Many people seem to regard the scope and benefits of the National Health Service as limitless, and do in fact use the Service as though that were the case. That such is not the case, successive Chancellors of the Exchequer have made abundantly clear, and they have in fact endeavoured to fix a "ceiling" beyond which the cost of the National Health Service may not rise. This necessary restriction on the size of the national bill for health services, means that within the National Health Service the various interests which provide health schemes and services have to compete with one another for a share of the limited total available. In such competition there is danger that the popular clamour for one type of service may ensure for it a larger share of the available funds than its real merit may give it title to. whereas the claims of less obviously beneficial parts of the service may suffer. Personally I should

need a lot of convincing, that the satisfying of the gargantuan thirst of the British public for liquid medicine is more important than the eradication of tuberculosis, or that the wholesale provision of dentures is more valuable than the care of those to whom age or chronic illness has brought infirmity. Most thinking people will agree that the logical way to approach the question of health in the nation is to adopt the positive approach—to teach people to acquire and promote good health in themselves and their families, and to keep disease at bay by preventing it. Yet in the present National Health Service the main emphasis is on curing disease, with preventive services a very poor second, being allocated only 8% of the 450 million pounds which the National Health Service claims from the national income. However wrong this outlook may be it will be very hard to alter it, and I see little prospect of a more logical approach to this question of health being adopted for many years ahead. Nevertheless it is something for which we must all strive, in our endeavour to make the best possible use of our limited national resources.

In the foregoing preface which will be common to the six Annual Reports I am called upon to write, I have touched upon these aspects of public health, and social medicine which seems to me to be important and to merit comment. Most of what I have had to say is not original, and has been much more convincingly and skilfully put by my colleagues in other parts of the country. The opinions and judgements I have formed are therefore not altogether my own, though their application to the area in which I work, and live is my responsibility. Some who read this Report will not agree with the conclusions I have reached and the opinions I have formed. I can only hope that in stimulating them to disagree with me, I may also stimulate them to seek after the best means of attaining our common goal—the good health and happiness of the community. We must all contribute in greater or lesser measure to the modifying and moulding of our social services so that they yield the best results. The National Health Service is one of the most recent arrivals on the scene, and it is without doubt one of the greatest experiments in social welfare so far undertaken in the world. To really succeed it will require all the support encouragement and guidance that thinking people everywhere can give.

I cannot conclude without thanking all who have assisted and encouraged me during the year 1950 in my endeavours to improve the health of the public in this part of Cornwall. May I hope that this co-operation will be extended to me as long as I continue to serve in this Area.

I have the honour to be

Mr. Chairman, Ladies and Gentlemen,

Your obedient Servant,

P. J. Fox,

Medical Officer of Health.

Liskeard Rural District.

Area of Rural District	104,803 acres
Population (Registrar-General's Estimate) ...	14,210
Number of Inhabited Houses	4,972
Rateable Value of Rural District	£64,444
Sum represented by Penny Rate	£263

Vital Statistics for 1950.

	Male.	*Female.*	*Total.*
Live Births	98	124	222

	L.R.D.	Health Area No. 7	England and Wales
Birth rate per 1000 of population ...	18.3	15.1	15.8

	Male.	*Female.*	*Total.*
Still Births	3	3	6

	L.R.D.	Health Area No. 7	England and Wales
Stillbirth rate per 1000 of population	0.42	0.32	0.37

	Male.	*Female.*	*Total.*
Deaths	115	101	216

	L.R.D.	Health Area No. 7	England and Wales
Death rate per 1000 of population...	11.9	13.7	11.6

Deaths attributed to Pregnancy, Childbirth and the Puerperal State

There was one death from these causes.

	L.R.D.	Health Area No.7	England and Wales
Maternal death rate per 1000 total (live and still births ...	4.39	1.24	0.86

Deaths of Infants under One Year of Age—

	Male.	*Female.*	*Total.*
	4	2	6

	L.R.D.	Health Area No. 7	England and Wales
Infant Mortality Rate per 1000 live births	27.0	18.9	29.8

Principal Causes of Death at all Ages

Heart disease	77
Cancer (all sites)	37
Respiratory disease	22
Intra-carnial Vascular lesions ("Stroke")	20
Genito-Urinary disease	7
Tuberculosis	6
Circulatory disease	5

Congenial Malformations	4
Digestive disease	4
Accidents	4
Suicide	2

	Males.	*Females.*
Average Age at Death	68.33	70.94

The above table of vital statistics show that the birth rate in the Rural District during 1950 was higher than that of the surrounding area, and of the Country as a whole. The death rate was only slightly above the national figure. Figures for maternal and infant mortality were not abnormally high. As far as the causes of death are concerned the incidence displayed is more or less that generally experienced and no special comment is necessary.

Infectious Disease. The incident of infectious disease in the Rural District during 1950 was the lightest for many years. During 1950 a total of 41 cases only was notified as compared with 334 in 1949, and 276 in 1948. Apart from 3 cases of polionyelitis no serious cases of infectious disease occured during the year, and there were no deaths from infectious disease.

The following are details of actual cases and case rates of infectious diseases during 1950 :—

		Case rate per 1000 of population		
Disease	**Cases**	**L.R.D.**	**Health Area No. 7**	**England & Wales**
Whooping cough	13	0.92	3.13	3.60
Pheumonia	13	0.92	1.26	0.70
Scarlet fever	5	0.35	0.84	1.50
Measles	3	0.21	0.44	8.39
Erysipelas	2	0.14	0.36	0.17
Paralytic poliomyelitis	2	0.14	0.19	0.13
Non-paralytic poliomyelitis	1	0.07	0.08	0.05
Meningitis	1	0.07	0.04	0.03
Acute Rheumatism	1	0.07	0.04	not known

Tuberculosis. There was some improvement in the position here as compared with previous years. During the year 7 new cases were notified as compared with 12 new cases in 1949, and 9 new cases in 1948. In 1950 there were 6 deaths, all from pulmonary tuborculosis, the figures here being on a par with 1949 when 6 deaths occured, and an increase over 1948 when 4 tuberculosis deaths took place.

The following are details of new cases, deaths, case rates and mortality from tuberculosis during 1950 :—

Age Group.	New Cases. M.	F.	Deaths. M.	F.
0 — 1	—	—	—	—
1 — 5	1	—	—	—
5 — 15	2	—	—	—
15 — 45	1	1	1	2
45 — 65	—	1	1	1
65 and over	1	—	—	—

Rates per 1000 of population

	Liskeard R.D.	Health Area No. 7	England and Wales
New cases	0.49	1.01	not known
All cases	3.52	5.12	not known
Deaths	0.42	0.40	0.36

The incidence of tuberculosis was heavier than normal in children below the age of 15 years, but the mortality from the disease ran more true to pattern in that young and middle aged adults were the victims. The tuberculosis case and mortality rates are not sufficiently abnormal to call for any special comment.

National Assistance Act 1948. No action under Section 47 of this Act was called for during 1950.

Water Supply. Towards the end of the year a start was made on the comprehensive scheme to abstract water from the River Fowey and supply it throughout the Rural District. The first stage involves the laying of a trunkmain from the Liskeard Borough Waterworks at St. Cleer to Polruan, where failure of the local supply is normal every summer. The early stages of this huge scheme have been beset by many difficulties not the least of which is the shortage of pipes and fittings, a shortage which is likely to become more serious as the rearmament drive gathers momentum. Whilst not wishing to be pessimistic in my outlook, I believe it will be many years before piped supplies of water will be generally available throughout the Rural District. Nevertheless it is good to see that a start has been made in this most important matter.

The small local supplies which now serve the Rural District continue to be unsatisfactory in both quantity and quality, though because of the wet summer of 1950, there were few failures in local supplies. Most of these supplies are from shallow wells and springs, and are liable to gross pollution. The report of the Sanatary Inspector shows that during 1950 unsatisfactory reports on samples were received in respect of many of these supplies, and it has been necessary to advise consumers to boil all such water when it is used for drinking. Some of these supplies could be improved, but the cost would be considerable and it hardly seems reasonable to spend money on them when the Council is so heavily committed in respect of its large scheme for the whole district.

Sewerage and Sewage Disposal. Work on the provision of a sewage disposal scheme for Seaton commenced in December

1950. This scheme is being undertaken in conjunction with the St. Germans Rural District Council. After a public inquiry held at Tremar Coombe in September 1950, the Ministry of Health approved the greater part of the scheme prepared for the sewering of St. Cleer and Tremar Coombe and it is hoped that work on this scheme will commence early in 1951. The cost of these schemes is now so great that it is not possible to engage in more than one or two such schemes simultaneously, although there is a widespread need and demand for such schemes in the district.

Food. Routine inspections of premises handling and serving food has been undertaken during the year, and during the summer months regular sampling of Ice Cream was in force.

Food Poisoning. No cases of food poisoning were notified during the year 1950.

Clean Food Campaigns. Because of the scattered nature of the Rural District no such campaigns were undertaken during 1950.

Factories Act 1937. The number and size of premises coming within the provision of this Act is not great and no difficulties have been encounted.

Housing. Lack of an adequate supply of wholesome piped water has been the greatest obstacle to the building of houses in the Rural District during 1950. As a result of this, and other difficulties associated with the building of small numbers of houses on widely scattered sites, only 6 new houses were completed and occupied during 1950. Towards the end of the year better progress was made and a further 42 houses were in course of erection.

Report of the Sanitary Inspector. The report of Mr. G. Rogers, M.R.S.I.,M.S.I.A., which follows gives a more detailed picture of the work undertaken by him during the year than that contained in my report. I should like to thank Mr. Rogers and Mr. Cowling for the ready co-operation and assistance they have afforded me during 1950.

APPENDIX 1.

Incidence of and Mortality from Tuberculosis in Health Area No. 7--1950

Age Group	*New Cases*		*Deaths*	
	Male	*Female*	*Male*	*Female*
0 — 1	—	—	—	—
1 — 5	2	—	—	—
5 — 15	5	2	—	—
15 — 45	13	18	7	4
45 — 65	6	2	4	2
65 and over	3	2	3	1
Totals	29	24	14	7

	Male	*Female*
Case rate per 1000 of population	0.55	0.46
Mortality rate per 1000 of population	0.27	0.13

Case Rates and Mortality Rates per 1000 of Population by Sanitary District in Health Area No. VII — 1950.

	New Cases	*Total Cases as at 31-12-50*	*Deaths*
Liskeard M.B.	2.30	5.99	0.46
Liskeard R.D.	0.49	3.52	0.42
Looe U.D.	1.08	5.92	—
St. Germans R.D.	1.07	6.50	0.44
Saltash M.B.	0.92	5.68	0.66
Torpoint U.D.	1.15	3.45	0.14
Health Area No. VII Cornwall	1.01	5.12	0.40
England and Wales	Not known	Not known	0.36

Water Supply.

The Spring and Summer of 1950 had more than an average rainfall, and for that reason there was no general shortage of water throughout the Rural District.

At Polruan water was raised from the bore-hole at Vevery by electricity throughout the Summer, but this, not being adequate, it was necessary to haul water from the Polperro mains supply. Each load was a 1,000 gallons, and a total of 451,000 gallons were delivered into the reservoir at Vevery between June 15th, and September 14th. Distribution of the limited supply was very much easier due to the fact that the mains throughout the whole of Polruan had been renewed.

Towards the end of 1950 the Ministry of Health gave approval to a tender of £51,844-8-9 for the laying of a trunk main from the Borough Council reservoir on St. Cleer Downs, to Polruan. Materials, already on order, began to come through before December, and the work will commence early in 1951. This will be the largest project ever undertaken by the Council, and is the commencement of a scheme which, it is expected, will supply the greater part of the Rural District with an adequate and wholesome supply of drinking water.

At Menheniot a branch main of 266 yards along East Street was completed by the end of November, and this enabled an adequate distribution to be made in an area where the supply had been bad for a long time.

The Council approved the laying of 574 yards of 2" cement asbestos main from the Borough of Liskeard to Island Shop for the

purpose of supplying six dwellings in that area. It is expected that the work will be carried out during the first quarter of 1951.

At St. Neot additional springs were collected at the source on Trevenna Farm and piped to the reservoir in order to maintain an adequate supply, especially at the high levels.

(1a) Quality. Twenty-one samples of water were taken from public and private supplies in the district during the year. Eleven of them were in connection with the following public or semi-public supplies.

Bodinnick. PUBLIC SHUTE. 2nd March 1950. Slight pollution of vegetable origin. Chemically satisfactory.

West Taphouse. STANDPIPE OFF RAM SUPPLY. 11th March 1950. Satisfactory from bacteriological and chemical viewpoints.

Golberdon. PUBLIC WELL. 20th March 1950. Satisfactory in all respects. Similar results when again sampled the 7th November, 1950.

Pelynt. VILLAGE SHUTE. 10th August 1950. Not satisfactoy. Pollution of excretal origin. Work to protect source unsuccessful. Consumers warned to boil water.

Darite. TAP OFF PUBLIC MAIN. 5th September 1950. Very satisfactory.

Lerryn. PUBLIC STANDPIPE. 26th August 1950. Water unsafe for drinking purposes. Unable to satisfactorily protect source of supply. Consumers warned to boil water.

Minions. SHALLOW WELL. 2nd October 1950. (Privately owned public supply). Unsafe for drinking purposes.

Minions. LAND SPRINGS. 2nd October 1950. Unsafe.

Minions. MINE ADIT. 2nd October 1950. A very satisfactory water.

Polruan. PUBLIC STANDPIPE. 7th November 1950. Polluted and unsafe for domestic purposes. Public advised to boil all water before drinking.

Polruan. PRIVATE TAP. 7th November 1950. Unsafe. The ten samples taken from private supplies resulted in 4 of them being found fit for domestic purposes. 4 slightly polluted but pollution chiefly of vegetable origin and 2 unsafe for drinking.

(b) Quantity. Except for Polruan the supply of water generally throughout the Rural District was adequate. Fuller details of the Polruan shortage and the steps being taken to obviate it in the future are given earlier in this report.

(c) Bacteriological Examination. A number of samples have

been taken for bacteriological examination and more full details given in paragraph 1 (a). No water supplies in this area are subject to any type of treatment.

(d) Plumbo-Solvency. None of the waters sampled was found to be plumbo-solvent, and no precautions were necessary to prevent action on lead pipes.

(e) Contamination of Supplies. Almost the whole of the Rural District is supplied from comparatively shallow springs or wells and in such cases it is very difficult indeed, if not impossible, adequately to protect them at all times from surface contamination. In most instances cattle and poultry as well as non domestic animals have access to the land in which the wells or springs are situated. If after taking all practical steps to protect the sources, results are found still to be unsatisfactory, consumers are warned that they should boil all water before drinking. The Council having been committed to a very extensive as well as expensive Water Scheme, it does not appear advisable to spend considerable sums of money on the attempts to protect properly, the numerous small individual supplies throughout the District.

(f) Parishes with one or more Villages having a piped water supply :—

Parish	*Population of Parish*	*Population supplied to houses*	*Population supplied from standpipes*
Broadoak	209	40	Nil
St. Cleer	1,485	850	37
Duloe	503	200	Nil
St. Ive	1,184	50	Nil
Lansallos	1,424	1,237	Nil
Lanteglos	1,320	1,000	150
Linkinhorne	1,139	120	120
Liskeard	922	Nil	300
St. Martins	283	140	Nil
Menheniot	1,089	220	20
Morval	530	34	Nil
St. Neot	918	140	100
Pelynt	452	50	Nil
St. Veep	362	25	Nil

Sewerage.

In December 1950 the Seaton Sewerage Scheme was commenced and the section in Keveral Lane was the first to be dealt with. The proposal is to sewer the whole of Seaton, both, the areas within the Liskeard and St. Germans Rural Districts, and to make a common sea outfall.

At Pelynt the sewerage treatment works were overhauled when the automatic syphon and spraying tubes were renewed.

In October orders were given for the renewal of a section of 9" sewer at Bodinnick, Lanteglos, in cast iron pipes. The original sewer was constructed of stoneware pipes, having very little cover, and these were badly damaged by heavy traffic. Owing to a long period of delivery it is not expected to complete the work until the end of the first quarter of 1951.

On September 9th, 1950 the Ministry gave approval in principal to the St. Cleer Sewerage Scheme, estimated to cost £19,339 and is the most extensive work of this kind ever undertaken by this Council. It is expected to commence early in 1951 and be completed the same year.

Meat and other Foods Only slaughtering of pigs for owners own consumption and a few emergency slaughterings have been carried out in the Rural District. In two cases the animals were found to be affected with generalised tuberculosis and were destroyed.

A number of inspections were made of other foods and the following were surrendered and destroyed :—

2 legs lamb — bone taint.
238 tins of various foods — blown, damaged or leaky.

Inspections were regularly carried out of the many cafes, restaurants and hotels in the District. Most of the premises were being kept in a clean and hygienic condition, and where suggestions for improvements were made, the occupier accepted them without difficulty.

Ice Cream—Retail Sale. The distribution points for the retail sale of Ice Cream increased during 1950 from 23 to 32. All were visited regularly to insure strict cleanliness. Most of the Ice Cream sold was pre-packed, and the danger of contamination was very much less than when the food is sold loose.

34 samples were taken for bacteriological examination and fat content. The latter in every case was good but the bacteriological condition was far from satisfactory.

The following will show the results.

Grade 1	3.
Grade 2	4.
Grade 3	16.
Grade 4	11.

As previously reported, the great proportion of Ice Cream sold was pre-packed and its condition as regards cleanliness was not influenced greatly by the retailer.

Obviously the trouble occured before it reached the retailer and only an improvement in the manufacturers premises could be effective. In every case the latter was in another District, and beyond the jurisdiction of this Council. Officers of the Districts concerned, took active measures to deal with the problem, with, it is hoped, more than a little success. Samples which will be taken during 1951 will provide the proof.

Food Poisoning. There was no cases of Food Poisoning reported in the Rural District throughout the year.

Food Campaigns. In an effort to emphasise the continued need of personal hygiene in the case of persons employed in the food trades, posters and handbills were displayed throughout the District.

On April 29th, 1950 the District Council adopted Byelaws under Food and Drugs Act, 1938 for securing the observance of sanitary and cleanly conditions and practices in connection with the Handling, Wrapping and Delivery of Food and Sale of Food in the Open Air. It is hoped that action under these Byelaws will not be necessary but the placing of responsibility on the employee as well as the employer, should do much to induce a degree of co-operation which is essential if hygienic conditions in catering establishments, and the food trades generally are to be maintained.

Housing. Difficulty in obtaining satisfactory sites tor the erection of Council Houses resulted in only six additional ones being completed and occupied during the year. Towards the latter part of the year, however, headway was made in the site problem to such an effect that by December a further 42 houses were in course of erection. 1951 should therefore see the completion of a substantial number.

Twenty dwellings, including bungalows, farm workers cottages and houses were completed by private individuals during the year. Some of these had been in course of erection over a very considerable period.

During the end of 1949 and the early part of 1950, twenty-five applications for Improvement Grants under Section 20 of the Housing Act, 1949, were received. Of those, 10 were refused, 1 withdrawn, and 6 approved, the remainder are under consideration. Of those approved, only one was completed by the end of the year. The restriction on building licensing prevents the consideration of many of these schemes.

All occupied Council Houses have been reasonably well maintained throughout the year and essential repairs were carried out with as little delay as possible.

Factories Acts, 1937 and 1948.

INSPECTIONS for purposes of provisions as to health (including inspections made by Sanitary Inspectors)

Premises	*M/c line No.*	*Number on Register*	*Inspections*	*Written notices*	*Occupiers prosecuted*
(*1*)	(*2*)	(*3*)	(*4*)	(*5*)	(*6*)
(i) Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by Local Authorities	1	51	46	nil	nil
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority ...	2	33	25	nil	nil
(iii) Other Premises in which Section 7 is enforced by the Local Authority † (excluding out-workers' premises)	3	15	35	nil	nil
TOTAL ...		99	106	nil	nil

Cases in which defects were found

Particulars	*M/c line No.*	*Number of cases in which defects were found.* *Found*	*Remedied*	*Referred To H.M. Inspector*	*By H.M. Inspector*	*No. of cases in which prosecution were instituted*
(*1*)	(*2*)	(*3*)	(*4*)	(*5*)	(*6*)	(*7*)
Want of cleanliness (S.1)	4	6	6	—	—	—
Overcrowding (S.2)	5	1	1	—	—	—
Unreasonable temperature (S.3)	6	—	—	—	—	—
Inadequate ventilation (S.4)	7	2	2	—	—	—
Ineffective drainage of floors (S.6)	8	—	—	—	—	—
Sanitary Conveniences (S.7)						
(*a*) insufficient	9	3	3	—	—	—
(*b*) Unsuitable or defective	10	7	7	—	—	—
(*c*) Not separate for sexes	11	—	—	—	—	—
Other offences against the Act (not including offences relating to Outwork)	12	—	—	—	—	—
TOTAL	60	19	19	—	—	—

OUTWORK (Sections 110 and 111)

Nature of Work	*M/c line No.*	*No. of out-workers in August list required by Section 110 (1) (c)*	*No. of cases of default in sending lists to the Council*	*No. of prosecutions for failure to supply lists*	*No. of instances of work in unwholesome premises*	*Notices served*	*Prosecutions*
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Wearing apparel— Making, etc. Cleaning and washing, etc.	13	3	—	—	—	—	—
TOTAL	70	3	—	—	—	—	—